CHAPTER 27

Rules and Regulations for Medicaid

Program Of All-Inclusive Care For The Elderly (PACE)

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-121 and the Wyoming Administrative Procedure Act at W.S. § 16-3-102.

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to the Medicaid services provided under the Wyoming Program of All-Inclusive Care for the Elderly (PACE) submitted to and approved by the Centers for Medicare and Medicaid Services (CMS) pursuant 42 C.F.R. §§ 460, 462, 466, 473, and 476.

(b) The requirements of Title XIX of the Social Security Act; 42 C.F.R. §§ 460,462, 466, 473, and 476; the Medicaid State Plan; and the three-way Program Agreement between the Sate, CMS and the PACE provider also apply to Medicaid and are incorporatedby this reference, and may be cross-referenced throughout this Chapter where applicable. This incorporation by reference is effective as of the filing date of this Chapter with the Secretary of State, and does not include any later amendments or editions of the incorporated matter. The incorporated rules and regulations may be viewed at http://www.ecfr.gov/cgi-bin/ECFR, www.ssa.gov, http://www.health.wyo.gov/healthcarefin/medicaid/spa.html section 3.1-A, and http://www.health.wyo.gov/healthcarefin/medicaid/homecareservices.html or may be obtained at cost from the Department.

Section 3. Definitions. Except as otherwise specified in Chapter 1, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid, and Medicare.

(a) "Program of All-Inclusive Care for the Elderly (PACE)." A capitated healthcare program designed to offer comprehensive health services and in-home care, includingsupportive services to help individuals maintain independence in the community for as longas possible.

(b) "Program of All-Inclusive Care for the Elderly Interdisciplinary Team (PACE IDT)." A team of medical and other professionals responsible for individualized care planning for PACE participants.

Section 4. Provider Participation and Enrollment.

(a) A provider that requests Medicaid reimbursement for services furnished toa participant shall meet the provider participation requirements of Chapter 3 and 42 C.F.R. § 460.200.

(b) A provider desiring the designation of PACE provider must complete and submit an application to CMS that describes how the applying organization meets all the requirements in 42 C.F.R. § 460.

(i) The application shall be competed in collaboration with the Department in accordance with CMS PACE application guidelines at www.cms.gov.

(ii) Upon completion of the application the applying organization shallsubmit it for review by the Department.

(iii) The Department shall review the PACE application to ensure compliance to State rules and regulations.

(iv) Once the Department has verified that the application adheres to State requirements for PACE, the application shall be submitted by the Department to CMSreview and approval.

(A) CMS evaluates PACE program provider applications inaccordance with CMS PACE application guidelines. The evaluation will include an on- site review at the provider's place of business by CMS and Department representatives.

(B) CMS provides notification of determination based on timelines outlined in 42 C.F.R. § 460

(v) Upon approval of the application, CMS, the Department, and the PACE provider shall sign a three-way Program Agreement authorizing the PACE providerto market and engage in enrollment activities, pursuant to 42 C.F.R. § 460, Subpart C.

(c) PACE provider employees and contractors who provide direct contact services to PACE participants shall meet the qualifications defined in 42 C.F.R. § 460.

Section 5. Eligibility, Applications, and Grievances for the PACE.

(a) Eligibility under this Chapter shall be limited to persons who:

(i) Meet current Medicaid income and resource eligibility through the process set forth in Chapter 18;

(ii) Are fifty-five (55) years of age or older;

(iii) Reside within the service area of a PACE provider;

(iv) Meet medical necessity for long-term care level of care determinationin accordance with Chapter 22; and

(v) Meet home assessment requirements demonstrating that the individualis able to live in the community setting without jeopardizing his or her health or safety, pursuant to 42 C.F.R. § 460.150.

(b) Participant application process.

(i) The Department and PACE providers shall provide applications for Medicaid enrollment to possible Medicaid eligible applicants.

(ii) Each applicant shall sign acknowledgement of informed consent for Medicaid participants electing to participate in the PACE program in lieu of receiving feefor-service Medicaid benefits. Completed Applications shall be submitted to PACEprovider.

(iii) The PACE provider shall ensure objective and nondiscriminatory enrollment practices without regard to religion, race, creed, national origin, economicstatus, sex, sexual orientation, or disability, which are applied equitably to all applicants.

(iv) The PACE provider shall verify that the applicant's age, zip code of residence, and Wyoming Medicaid eligibility are consistent with the eligibility criteria.

(v) The PACE provider shall request an evaluation of medical necessity in accordance with Chapter 22.

(vi) The PACE provider shall conduct a home assessment to verify the ability of the applicant to live safely in the community pursuant to 42 C.F.R. § 460.150.

(vii) Upon notification of eligibility status by the Department, the PACE provider shall contact the prospective applicant. If eligible and the prospective applicant chooses to enroll, an enrollment agreement shall be signed by the applicant. The applicant's enrollment in the program is effective on the first day of the calendar month following the date the PACE program provider receives the signed enrollment agreement.

(viii) All applications denied by the PACE program provider must be submitted to the Department or its designee for review pursuant to 42 C.F.R. § 460.152

(c) Loss of eligibility.

(i) A participant shall be determined to be no longer eligible for PACE program services when the participant:

(A) Does not meet Medicaid financial eligibility requirements as determined by the Department or its designee pursuant to Chapter 18; or

(B) Is determined to no longer meet the Medicaid medical necessity requirements pursuant to Chapter 22;

(ii) A participant may request a hearing regarding loss of Medicaid eligibility through the process set forth in Chapter 18, Chapter 22 and Chapter 4.

(d) Grievance procedure. Wyoming PACE participants, their representatives, and others have the right to have their complaints and grievances addressed by the PACEProvider or the Department, in a timely, reasonable, and consistent manner without concernthat making a complaint and grievance will negatively affect their treatment in any manner.The formal grievance procedure is outlined in the three-way Program Agreement betweenthe State, CMS, and the PACE provider.

Section 6. Participant Disenrollment Procedures.

(a) Involuntary disenrollment. All involuntary disenrollments must meet the criteria set forth in 42 C.F.R. § 460.164 and be approved by the Department or its designeeprior to thirty (30) day notification to the participant of involuntary disenrollment.

(b) A participant shall be determined to be no longer eligible for PACE program services and therefore involuntarily disenrolled when:

(i) The participant moves out of the PACE provider service area or is out of the service area for more than thirty (30) consecutive days, unless the PACE provideragrees to a longer absence due to extenuating circumstances;

(ii) The participant has a demonstrated history of ongoing, willful non-compliance with an essential treatment plan or engages in disruptive or threateningbehavior that jeopardizes his or her health or safety or the safety of others;

(iii) The PACE provider's agreement with CMS and the Department is not renewed or is terminated; or

(iv) The PACE provider is unable to offer health care services due to theloss of contracts with outside providers.

(c) Voluntary disenrollment. A PACE participant may request voluntary disenrollment from the program at any time. The PACE provider shall assist any participantwho wishes to return to fee-for-service by making appropriate referrals and helping the participant to complete release of information requests in advance of disenrollment so thatmedical records can be made available to new providers.

(d) Continuation of PACE services. The PACE program provider shall continueto provide all needed services until the date of disenrollment.

~~Section 7. Covered Services.~~

~~(a) Providers shall provide services and conduct activities as outlined in42 C.F.R. § 460, 462, 466, 473, and 476.~~

~~(i) Services shall be available twenty-four (24) hours a day, seven (7) daysa week by a PACE provider approved by CMS.~~

~~(ii) Services provided by the PACE provider shall include:~~

~~(A) Primary care, including physician and nursing;~~

~~(B) Social services;~~

~~(C) Restorative therapies, including physical therapy and occupational therapy;~~

~~(D) Personal care and supportive services;~~

~~(E) Nutritional counseling;~~

~~(F) Recreational therapy; and~~

~~(G) Meals.~~

~~(b) Each PACE participant shall have an individualized plan of care developedand approved by the PACE IDT.~~

~~(i) Each plan of care shall encompass the following services:~~

~~(A) Adult day health services;~~

~~(B) Acute, long-term care, if needed;~~

~~(C) Pharmacy;~~

~~(D) Transportation; and~~

~~(E) Home care.~~

~~(ii) Additional services may be deemed necessary by the PACE IDT and included in a participant's individualized plan of care.~~

~~Section 8. Transfers between PACE and Other Medicaid Long Term Careprograms.~~

(a) The PACE provider shall assist the participant in completing all forms or referrals necessary to enroll the participant in other available Medicaid long-term care programs if it is determined the participant will be voluntarily or involuntarily disenrolledfrom the PACE program provider.

(b) Participant enrollment is based on monthly coverage, so participant coverage under a PACE provider will be effective until the end of the month of PACE disenrollment. A participant cannot be enrolled with a PACE provider for part of a monthand enroll in another Medicaid long-term care program for part of the same month.

(c) The PACE program provider shall coordinate with the Department todetermine a participant's disenrollment date to ensure continuity of care.

Section 9. Provider Payment.

(a) Provider payment is based on a capitated rate calculated on a per member per month (PMPM) methodology. The payments will be automatically generated by the Medicaid Management Information System (MMIS) based on the individuals that are enrolled in the PACE provider's program on the system.

(b) Capitated rates calculation.

(i) Capitated rates shall be no less than ninety percent (90%) of the fee-for-service equivalent cost, including the cost of administration that the Departmentestimates would be payable for all services provided by the PACE provider if all of those services were to be provided on a fee-for-service basis.

(A) The non-PACE population group used to determine the PMPM capitated rate must include individuals that match the participant criteria for thePACE program as described in Section 5.

(c) The monthly capitation payments shall be considered full payment for all services provided for PACE participants.

Section 10. Recovery of Overpayments. The Department shall recover overpayments pursuant to the provisions of Chapter 16.

Section 11. Audits. All audits shall be subject to the provisions of Chapter 16.

Section 12. Reconsideration and Administrative Hearings. A provider may request reconsideration of the decision to recover overpayments pursuant to the provisionsof Chapter 16.

Section 13. Disposition of Recovered Funds. The Department shall distribute recovered funds pursuant to the provisions of Chapter 16.

Section 14. Interpretation of Chapter.

~~(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.~~

~~(b) The text of this Chapter shall control the titles of various provisions.~~

~~Section 15. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department or its designee, including manuals and bulletins, which are inconsistent with this Chapter.~~

~~Section 16. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.~~